Medical Services

BIPOLAR DISORDERS

Version 2 Final

Document control

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Changes since last version

Section 2.2 - Non-Genetic Factors

Section 4.0 Diagnosis

Section 5 Treatment

Section 7.2 ESA Considerations

Appendix A – ICD-10

1. Description

1.1. Classifications and synonyms

Bipolar disorders are recurrent affective disorders characterised by episodes of mania or hypomania. They are usually separated by periods of depression but the term is now used even in cases where a depressive episode has not occurred, on the grounds that most patients with recurrent mania will also experience episodes of depression in time.

Various patterns have been recorded, and subgroups recognised.

The term bipolar disorder is now preferred to previously used labels such as manic depressive psychosis or manic depressive illness.

The two internationally recognised classifications of mental illness are ICD-10[1] and DSM-IV.[2] These descriptive classifications are broadly similar.

In the UK and Europe, ICD-10 is widely used, though there is a degree of overlap with DSM-IV, particularly in the clinical research environment. DSM-IV is produced by the American Psychiatric Association, primarily for use in the USA.

The two classifications complement each other, and to assist the understanding of bipolar disorders, terms from both are referred to in this protocol.

The main similarities and differences between the two classifications are as follows:

- Both define individual episodes and patterns of recurrence
- Both use severity of symptoms and impaired social functioning to distinguish hypomania from mania
- A single episode of hypomania or mania fulfils the diagnostic criteria for bipolar affective disorder in DSM-IV
- At least two episodes of mood disturbance, including one where mood has been elated, are required for the ICD-10 criteria for bipolar affective disorder

DSM-IV subdivides bipolar disorders into the following subgroups:

- Bipolar I – where an episode of mania has occurred at least once
- Bipolar II – where there has been hypomania, but mania has not occurred

The different diagnostic codes and criteria for ICD-10 relevant to this protocol, some further information about DSM-IV, and more detail about the diagnostic differentiation between hypomania and mania have been included in the Appendix.

2. Aetiology

The German psychiatrist Kraepelin first used the term manic-depressive insanity in the early 1920's, highlighting in particular the differences between these patients and those with schizophrenia, (then termed dementia praecox).

The term bipolar was not introduced until the 1960's, when clearer distinctions between unipolar and bipolar illness were drawn. Since that time there has been much research into possible aetiological factors.

A variety of theories on aetiology have been explored, and it seems likely that genetic and environmental factors combine to induce the psychological and biological features that underlie bipolar disorders.

2.1. Genetic factors

Of all psychiatric conditions it seems that bipolar disorders are amongst the most genetically determined.[3]

Many family studies have shown that the risk of a first-degree relative of a patient with a bipolar disorder developing the condition is approximately 9%. This is substantially greater than the risk in the general population. Non-genetic factors could contribute to these risks, but the importance of genetics is strongly supported by evidence from twin studies indicating that monozygotic twins exhibit a concordance rate of approximately 40% while the rate for dizygotic twins is much less at approximately 5%.[4]

Whether bipolar l and bipolar II are genetically separate entities is not clear.[4]

Although genetic factors are recognised as being of importance, the mechanisms are still unclear. The search for specific genes associated with bipolar disorders is progressing,[3] but since concordance in monozygotic twins is not 100%, it is clear that non-genetic factors must contribute, and the possibility that they may do so through their effects on gene expression is gaining favour.[5]

2.2. Non-genetic factors

Early environment

Childhood experience of relationship difficulties, abuse, and neglect appears to be associated with increased risk of bipolar disorder later in life, especially in the genetically vulnerable.[6]

Ongoing environment and life events

A wide range of circumstances may trigger bipolar episodes in predisposed individuals. There may be ongoing vulnerability factors such as lack of a confiding

relationship, poor social support, not working outside the home, or having the care of young children. There may also be stressful factors such as problems with housing, in marriage, or at work. Adverse life events such as bereavement may contribute. However in all of the above examples, triggering of depression rather than mania is more likely. Manic symptoms may be triggered by a disruption in a person's sleep pattern e.g. following a long haul flight or by doing shift work. They may even arise when an important goal has been achieved; illness triggered by positive rather than negative circumstances.

Altered physiology and physical disease

Childbirth is one of the most wellknown triggers of mania with between 25-50% of women with bipolar becoming unwell in the immediate postpartum period. Other alterations in physiological states such as endocrine disorders (e.g. Cushing's disease, Addison's disease, hypothyroidism, and hyperparathyroidism), some infections, prescribed medication (e.g. steroids) and some diseases of the brain may also precipitate affective illnesses, including bipolar disorders, the condition then being referred to as an organic mood disorder.

Substance abuse

Abuse of substances, including alcohol, occurs more often in individuals with a bipolar disorder than in the general population. However, it is not clear whether such abuse may contribute to the development of the disorder or whether proneness to bipolar disorders may underlie a tendency to substance abuse.[7]

Psychological factors

Genetics, early environment, and the growing experiences of life mould an individual's personality, cognitive style, and range of strategies for coping with problems of both short and long duration. Certain variants of these attributes can be associated with development of bipolar symptoms. For example, individuals who focus excessively on their performance, set themselves high standards, are self critical, and who tend to dwell on negative thoughts appear to be vulnerable to development of bipolar symptoms when confronted by events that they perceive to be adverse, or when experiencing ongoing mental stress.[8]

Neurobiological factors

Brain imaging techniques have shown that bipolar disorders are associated with structural alterations and dysfunction in areas of the brain. It remains uncertain whether such changes are genetically determined or develop in response to adverse factors arising as life progresses, or both.

It has been known for some time that dopamine agonists such as bromocriptine can produce manic states, but it is not clear whether this is due to localised increase in levels of dopamine or to increased sensitivity to its actions. Certainly there is now evidence that some of the medications used to treat mania act on the dopaminergic system.

3. Prevalence

Bipolar disorders can occur at any age from early adolescence to old age, and unlike depressive disorders, there are no evident gender differences. Childhood cases have been reported very occasionally.

On average, the condition is first diagnosed during the late teens to early to mid twenties. This is an earlier age of onset than for major depression.

In European countries both the point prevalence and lifetime prevalence are approximately 1%; an indication of the chronic nature of the disorder.[9]

Some studies have shown a higher prevalence in higher social classes. It is not clear whether this is a true picture or whether it simply highlights differences in access to mental healthcare.

Mania has been described within a wide range of cultures, with little cross-cultural variation.[10]

4. Diagnosis

4.1. Clinical features

The mood changes that characterise bipolar disorders usually include episodes of depression. These, in their various forms, are described in some detail in a separate protocol (Depressive Disorders). The relevant clinical features of depression will therefore not be described in any depth here.

An explanation of some common terms will help in understanding the clinical features.

Mood – This is a pervasive and sustained emotion. In the extreme, it markedly colours a person's perception of the world.

Elation – This is an elevated mood or exaggerated feeling of wellbeing, which is pathological and is a feature seen in mania.

Affect – This differs from mood in that it is much less sustained, often varying in the short term. It can best be described as a pattern of observable behaviours that are the expression of a subjectively experienced emotional state.

Mania and Hypomania – These represent different degrees of severity of mood elevation. In hypomania, the clinical features are less marked, and although day-to-day functioning will be affected, the clinical picture is less florid than that seen in mania. Psychotic features such as delusions or hallucinations are not seen in hypomania. In mania, the clinical features are much more marked and the individual's condition may rapidly decline to one of self-neglect, with features such as poor personal hygiene. Inattention to nutritional needs may lead to dehydration. Sustained physical overactivity and aggressive or violent behaviour may ensue.

In general, patients with hypomania or mania will display the following:

- Elevation of mood (although angry or irritable mood can also be displayed)
- Increased activity
- Self-important ideas

Physical appearance may be unusual or altered:

- Brightly coloured or ill-assorted clothes may be worn
- Appearance may be dishevelled and untidy
- They may appear to fluctuate between overactivity and physical exhaustion

Observations of speech and thought processes may highlight:

- Rapid or copious speech, often termed ‘pressure of speech’, (‘punning’ [word play] or ‘clanging’ [selecting words because of sound or rhyming rather than meaning] may feature)

- Expansive or unrealistic ideas

- ‘Flight of ideas’. This is where thoughts follow in rapid succession and appear to be connected by chance, although some association can be gathered by the listener (mania only)

- Extravagant or grandiose delusions (mania only)

An example of speech with clang associations would be ‘Birmingham, Kingstanding; see the king he’s standing, king, king, sing, sing, bird on the wing’.

Flight of ideas can be so marked that speech becomes incoherent. In hypomania the overall train of thought is better retained.

History taking or information from a third party may provide descriptions of the following:

- Increased energy

- Increased appetite

- Loss of normal social and sexual inhibitions

- Overspending

- Increased distractibility

- Reduced need for sleep

- Starting many tasks or activities but failing to complete them

- Poor attention span and ability to concentrate

These relevant features may not be reported by the patient, who may lack insight into their condition.

As the patient deteriorates, these features may change, and delusions of persecution, ‘ideas of reference’, or passivity feelings may become manifest. At this point the patient is described as experiencing “mania with psychotic symptoms”. It is estimated that 60% of bipolar patients will have psychotic symptoms at some time during their illness.

In such cases, hallucinations are common. Auditory hallucinations may be in the form of voices indicating that the patient has special powers. Visual hallucinations frequently have a religious content. Insight is frequently absent or variable.

The clinical picture may be mixed, with depressive and manic symptoms occurring at the same time. In these cases, referred to as being in a “mixed affective state”, a

rapid sequence of changes in symptoms may be seen.

4.2. Manic stupor

The clinical picture of a patient presenting in a manic stupor is very rarely seen now. The face has an elated appearance, and although fully conscious, the patient remains mute, unresponsive and akinetic [motor and psychic hypoactivity] throughout. On recovery he or she may remember having had 'flight of ideas'.

4.3. Rapid cycling disorder

Where the pattern of relapse and remission is frequent, (at least 4 episodes of illness a year), the condition is called rapid cycling disorder. The episodes may be manic, depressive, or have a mixed picture. This variant can be triggered by anti-depressants, is more frequently seen in women, and can be associated with concomitant hypothyroidism. Unfortunately, lithium treatment is relatively ineffective in these cases.

4.4. Bipolar III disorder

This controversial subtype with varying definitions has been described by clinicians, but is not included in ICD-10 or DSM-IV.[11] It is also referred to as bipolar spectrum disorder. Individuals with this condition have recurrent depressive episodes, with clinical features suggesting they may develop a bipolar disorder. These include pre-morbid personality, family history of bipolar disorder, and hypomania in response to anti-depressants.

4.5. False unipolar disorder

This term may be applied to recurrent depression originally classified as unipolar, where mania or hypomania develops subsequently. It has been estimated that between 10.7% and 28.4% of those diagnosed with unipolar depressive disorder are 'false unipolars'.[11]

4.6. Cyclothymia

Although not included in the ICD-10 classification of bipolar disorders, it is convenient to make mention of cyclothymia at this point. It is classified as one of the persistent mood (affective) disorders in ICD-10.

The disorder is characterised by persistent instability of mood, featuring episodes of both mild elation and depression. Episodes are neither severe enough nor of sufficient length for diagnostic criteria of other conditions to be satisfied. It is common in relatives of patients with bipolar disorders, and a significant number (30%) will at some point go on to develop a bipolar disorder themselves.

4.7. Dysthymia

It is also convenient at this juncture to make brief mention of dysthymia, another persistent mood (affective) disorder. Essentially, the relevant clinical feature here is a low mood which although persistent and long standing, is never (or almost never) severe enough to fulfil the ICD-10 criteria for a recurrent depressive disorder (mild or moderate severity). The duration will be of years, and can last indefinitely.

Other synonyms for this include depressive neurosis, depressive personality disorder, neurotic depression (with more than 2 years duration) and persistent anxiety depression.

There is no association with the development of a more disabling mood disorder later in life.

4.8. Investigations

Assessment of patients with a suspected bipolar disorder requires careful history taking and physical examination to exclude other possible conditions (see **4**.**9**).

Information obtained from a relative or carer can prove vital, as the patients may be unable to recognise the extent of their own abnormal behaviour.

In mania, hospital admission is likely to be advisable, as effective care at home is very difficult to achieve.

The following baseline investigations should be carried out to exclude other conditions such as anaemia, electrolyte disturbances or the effects of vitamin deficiencies. Metabolic disorders can also impact on prescribed therapy and need to be identified before treatment commences:

- Full blood count
- Urea and electrolytes
- Thyroid function tests
- Liver function tests
- Vitamin B12 and serum folate levels
- Syphilis serology
- Urine tests – including a screen for illegal substances
- EEG
- Psychometric testing

4.9. Differential diagnosis

A number of other conditions can present features suggestive of hypomania or mania, and must be excluded by clinical assessment and appropriate tests.

- Organic disorders:
  - Delirium/ acute confusional state
  - Frontal lobe disease (dementia, tumour or HIV infection)
  - Other neurological cause (epilepsy, post CVA, MS)
  - endocrine disorder (hyperthyroidism, Cushing's syndrome)
  - secondary to prescribed medication (corticosteroids, L-dopa, anti-depressants)
- Psychoactive substance use disorder (alcohol, amphetamines, cocaine)
- Schizophrenia / schizoaffective disorders
- Acute and transient psychotic disorder
- Agitated depression
- Obsessive compulsive disorder (elation is not usually a feature here)
- Personality disorder (emotionally unstable or dissocial)
- Attention deficit hyperactivity disorder (elation is not usually a feature here)

4.10. Comorbidity with other mental health conditions

This is common and likely to increase disability significantly. Relevant conditions include abuse of alcohol and other substances, anxiety disorders, social phobias, and post-traumatic stress disorder.[12]

Alcohol abuse is 3 to 4 times more likely to occur during the lifetime of patients with a bipolar disorder than in the general population, and mood disorders are approximately 10 times more likely during the lifetime of those with an alcohol dependence problem.[13]

Comorbid conditions are likely to have a significant impact on factors such as response to and compliance with treatment, social functioning and employment prospects.

5. Treatment

People with bipolar disorders are commonly encountered in the primary care setting, although most are likely to be in contact with specialist mental health services and care is usually provided by both.

The management of bipolar disorders can usefully be divided into the treatment of acute episodes and long-term strategies to prevent relapse.

5.1. Management of acute mania/hypomania

This is best undertaken in a hospital setting. Whilst informal admission is preferable, compulsory admission under the Mental Health Act may be necessary if the patient's wellbeing or personal safety is seriously compromised.

Drug treatment forms the backbone of therapy in the acute phase. If the patient is already on an antidepressant this should be stopped. If not on any anti-manic medication the first drug of choice would be an antipsychotic. Antipsychotics act not just to treat psychotic symptoms but variably have sedative, anxiolytic, anti-manic and anti-depressant properties, therefore treating multiple aspects of a bipolar illness.

Atypical antipsychotics (olanzapine, risperidone, quetiapine and aripiprazole) are preferable to typical antipsychotics (haloperidol and chlorpromazine) due to their better side effect profile and the fact that manic patients may be particularly susceptible to extrapyramidal side effects.

The **mood stabilising drugs** lithium or valproate may also be used first line, particularly if the person has shown a previous good response to these drugs and if the illness is a little less acute. Combining one of the mood stabilisers with an atypical antipsychotic gives better results than a mood stabiliser alone, especially if there had been only partial response to one drug.

If use of one drug alone proves ineffective, a combination of a mood stabiliser and an antipsychotic or 2 mood stabilisers may be tried.

In the short term, **benzodiazepines** may be added to restore normal sleep pattern and to reduce agitation. Their use also allows lower doses of other antipsychotic drugs to be prescribed.[14]

Electroconvulsive therapy (ECT) is effective in about 80% of patients with acute mania. In practice, it tends to be used in patients who have failed to respond to medication, or those with very severe illness, rather than as a first option.

5.2. Management of bipolar depression

A person with a bipolar illness will spend approximately 50% of the time with clinical symptoms, and of these the vast majority will be depressive symptoms. It is

therefore very important to recognise and treat a bipolar depression. Although clinically a bipolar depressive episode presents in largely the same way as a unipolar depression, the treatment is not the same. Unfortunately there is not a good body of evidence for the treatment of bipolar depression.

Antidepressants should not be used alone due to the risk of triggering a switch to a manic state[15]. Better first line options are mood stabilisers (lamotrigine may be better than valproate and lithium) or antipsychotics (the best evidence base currently being for quetiapine). In patients who do not respond, an antidepressant (SSRI class is considered least likely to provoke a manic episode[16]) in combination with an anti-manic drug may be used. ECT should also be considered if symptoms are severe.

5.3. Longer term management

The aim here is to prevent relapse or recurrence. Long term treatment should be offered after one severe episode of mania or after 2 less severe episodes of illness and should be offered for at least 2 years. Even then, given the risk of relapse remains constant , there should be good reason for stopping treatment.

The drugs available for long term use tend to be better at preventing relapse of either mania or depression. The choice of drug should therefore depend on whether the patient tends to experience more manic or more depressive episodes. Lithium, olanzapine, risperidone, aripiprazole and valproate seem better at preventing mania while lamotrigine protects against depression. Quetiapine may be good at preventing both.

Lithium is an effective prophylactic agent and remains one of the drugs of choice for long term management of bipolar disorders.[17,18] Experience with it has resulted in its use as first line therapy but certain factors may favour one of the alternatives. It is effective in preventing recurrences of mania but less effective for depression, although it may significantly reduce suicide rates.[19]

If any of the following features are present then an alternative may be preferred:

- Chronic depression
- Rapid cycling disorders
- Mixed affective states
- Alcohol and drug misuse
- Mood incongruent psychotic features

Contraindications to lithium treatment include:

- Renal insufficiency
- Cardiovascular insufficiency
- Addison’s disease

- Untreated hypothyroidism

Lithium is a toxic drug with a narrow therapeutic window and it can be fatal if taken in overdose. Patients need to have regular monitoring of blood levels whilst taking lithium. The target blood level is 0.4-1.0 mmol/l 12 hours after the evening dose.

Potential side effects from lithium include:

- Gastrointestinal disturbances
- Fine tremor
- Polyuria and polydipsia
- Weight gain
- Oedema
- Subjective memory disturbances

Signs of lithium intoxication include CNS disturbances, such as ataxia, coarse tremor and drowsiness.

Lithium can interact with a wide range of other prescribed drugs. Diuretics, in particular thiazides, should be avoided if possible.

All the alternatives have their own reported side effects and the benefit – side effect balance has to be tailored to the individual. MIMS or the BNF should be consulted for guidance on potential side effects.

5.4. Cognitive behavioural therapy

Cognitive therapy can have a useful supporting role in the treatment of bipolar patients.[20] It may help the individual to understand the illness, the need for treatment, and how to resist negative thoughts or maladaptive beliefs. It may also help patients to identify early signs of manic relapse.

5.5. Compliance

Compliance is an important issue in the management of patients with bipolar disorders. The reasons for non-compliance with treatment are complex. Some patients may be reluctant to stop experiencing the elevated mood swings that they perceive as being pleasurable. Side effects of medication may prove problematic, as may the need for regular blood test monitoring.

An interesting first hand account describing what it is like to have a severe bipolar disorder has been written by Dr Kay Redfield Jamison, herself a respected world authority on the subject.[21] She describes the personal dilemmas inherent in coming to terms with both the diagnosis and the management of the condition. It can

certainly not be assumed that detailed knowledge of the condition will in itself ensure good compliance.

For patients who are on lithium, poor compliance is a major issue, as sudden discontinuation can precipitate illness recurrence.[22]

6. Prognosis

The average manic episode, treated or untreated, lasts 6 months.

Functional prognosis in terms of factors such as employment is similar to other severe mental illnesses such as schizophrenia.

90% of patients who have had a manic episode will have a manic or depressive recurrence.

Less than 20% of bipolar patients are able to achieve a 5-year period of clinical stability, and social and occupational performance are both significantly reduced.

Long-term follow-up studies (25 years) have shown that the average bipolar patient will have 10 further episodes of mood disturbance. The time interval between relapses tends to shorten with both increasing number of episodes and ageing.

It is estimated that 10% of patients diagnosed with a depressive disorder will go on to have a manic illness.

There is a substantially higher suicide rate amongst bipolar patients than in the general population,[23] and the percentage of bipolar patients who attempt suicide at some point in their illness is estimated to be in the region of 50%.

In addition to suicide risk, there is an increased premature mortality rate due to medical conditions, and unhealthy lifestyle and adverse effects from drugs may be contributory factors.[24]

Patients with Bipolar II disorder seem to have a better general prognosis (but retain the same suicide risk).

Cyclothymia usually runs a chronic course, with 30% of patients going on to develop a full-blown bipolar disorder.

In conclusion, in spite of available effective treatment for bipolar disorders, the long-term functional prognosis for these conditions remains disappointing, with high levels of mental health disability likely.

7. Main Disabling Effects

Bipolar disorders are considered to be amongst the 10 leading causes of disability world-wide, in adults aged 15-44 years.[25]

In general, rates of relapse are high, and disabling mood symptoms are likely to persist between relapses.[27]

These conditions can cause severe disruption to daily life, affecting all aspects.

In severe cases, the ability to attend to personal hygiene and nutritional needs will be affected.

Motivation, concentration and cognitive ability may be reduced, affecting the ability to complete even simple daily tasks effectively.

Social interaction is frequently compromised, affecting relationships with others both inside and outside the home. This feature is persistent, and evident both between and during relapses.[26,27] Research has consistently shown that long term psychosocial functioning is poor in up to 60% of patients.[27]

A study carried out in the UK, which looked at various aspects of social functioning, found that within the work environment, the following factors may be seriously affected:[28]

- Timekeeping
- Unauthorised absence
- Relations with peers and supervisors
- Quality or quantity of output

Despite surveys showing that most people with severe mental illness would prefer to be able to work, unemployment figures amongst this group remain high.[29]

In the USA, the unemployment figures range from 75-85%. In the UK the range is from 61-73%.[30]

A survey carried out by the Manic Depression Fellowship found that whilst 69% of those responding wanted to work, and 40% were graduates, only 19% were in full time employment.[27]

In order to help those with severe mental illness to remain in the workplace it is thought that supported employment, (placement in competitive employment whilst offering on-the-job support), is more effective than pre-vocational training, (a period of preparation before entering competitive employment).[32]

In the USA, supported employment schemes are more widely available compared to the UK, where prevocational training is more likely to be offered.

7.1. Assessing the Claimant

The history obtained from the claimant should be comprehensive, with careful attention paid to looking for consistency between the history, and all other evidence available.

Lack of insight and poor compliance are common features of these conditions, and although these may be obvious in some cases, may not be so apparent in others. Evidence for these features should therefore be actively sought. The mental state examination should cover these and all other relevant aspects. If mood is abnormally depressed or elevated, then this may well influence history features offered by the claimant.

If the claimant is seen with a companion, and wishes him or her to be present during the assessment, it may be possible to obtain useful 'third party' history about both past and present features. This may provide vital supporting evidence about their disability.

Variability is a strong feature of these conditions, and may prove difficult to address. Attempts to ascertain how the claimant is most of the time should be made.

7.2. ESA Considerations

As noted because of the lack of insight appropriate consideration must be given to the evidence of accompanying friends, relatives or carers. Elements or inconsistencies in the typical day may reflect this.

Mental state examination may give an indication of memory and concentration problems, while elation affect and speech may indicate that mania should be clearly considered and addressed.

Aggression may be observed and considered appropriately in line with accepted diagnoses. Aggression may have to be addressed within appropriateness of behaviour.

Where mania is a component the recognised effects of lack of attention to personal hygiene and ability to maintain nutrition may indicate consideration be given to personal action descriptors.

As noted concurrent depression and other mental health problems are frequently present and the co-morbid effects may form part of the justification of other appropriate advised descriptors.

Hallucinations and extremes of elation of mood may suggest that consideration be given to the non-functional descriptor of "substantial risk to any person".

In most instances episodes last for 6 months or more and prognostic advice should reflect this.

Appendix A - Diagnostic codes and criteria

ICD-10

Using ICD-10 criteria, hypomania is diagnosed if mood is elevated or irritable to an abnormal degree for that individual and is sustained for at least 4 consecutive days. Three of the following must be present, leading to some interference with personal functioning:

- Increased activity or physical restlessness
- Increased talkativeness
- Difficulty in concentration or distractability
- Decreased need for sleep
- Increased sexual energy
- Mild overspending, or other types of reckless or irresponsible behaviour
- Increased sociability or overfamiliarity

For mania to be diagnosed, mood must be abnormally elevated or irritable and be prominent and present for at least a week. Symptoms must be severe enough to disrupt work or social activities more or less completely. At least three of the following must be present:

- Increased activity or physical restlessness
- Increased talkativeness
- Flight of ideas
- Loss of normal social inhibitions, resulting in behaviour that is inappropriate to circumstances
- Decreased need for sleep
- Inflated self-esteem or grandiosity
- Distractibility or constant changes in activity or plans
- Behaviour that is foolhardy or reckless and whose risks the individual does not recognise, e.g. spending sprees
- Marked sexual energy or sexual indiscretions

Mania is further classified depending on the presence or absence of psychotic symptoms.

The ICD-10 codes for the conditions discussed in this protocol are as follows:

F30 Manic episode

F30.0 Hypomania

F30.1 Mania without psychotic symptoms

F30.2 Mania with psychotic symptoms

F30.8 Other manic episodes

F30.9 Manic episode, unspecified

F31 Bipolar affective disorder

F31.0 Bipolar affective disorder, current episode hypomanic

F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms

F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms

F31.3 Bipolar affective disorder, current episode mild or moderate depression

.30 Without somatic syndrome

.31 With somatic syndrome

F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms

F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms

F31.6 Bipolar affective disorder, current episode mixed

F31.7 Bipolar affective disorder, currently in remission

F31.8 Other bipolar affective disorders

F31.9 Bipolar affective disorder, unspecified

F34 Persistent mood [affective] disorders

F34.0 Cyclothymia

F34.1 Dysthymia

DSM-IV-TR

For hypomania to be diagnosed using DSM-IV, there has to have been elevated mood for at least 4 days. In addition, at least 3 additional symptoms from the following list must be present:

- Inflated self esteem or grandiosity (non-delusional)
- Decreased need for sleep
- Pressure of speech
- Flight of ideas
- Distractibility
- Increased involvement in goal-directed activities or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences

There should be no evidence of delusions or hallucinations.

Hypomania can be diagnosed if the mood is irritable rather than elevated, but in this instance, 4 of the above additional symptoms are required.

For mania to be diagnosed, the abnormal mood must last at least a week (less if the person is hospitalised). Again, there must also be 3 or 4 of the above symptoms depending on whether the mood is elevated or just irritable. There must also be marked impairment of social or occupational functioning, hospitalisation or the presence of psychotic features.

In DSM-IV, the diagnostic criteria are grouped as follows:

Bipolar I disorder

Single manic episode

Most recent episode hypomanic

Most recent episode manic

Most recent episode mixed

Most recent episode depressed

Most recent episode unspecified

Bipolar II disorder

Specify current or most recent episode hypomanic/ depressed

Cyclothymic disorder

Bipolar disorder not otherwise specified

Numerical codes are allocated which specify one of the above conditions. Severity, presence and absence of clinical features, and pattern of relapse and recovery are also indicated by the code used.

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